

Introduced by Senator HernandezFebruary 19, 2014

An act to amend Section 1373.96 of the Health and Safety Code, and to amend Section 10133.56 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1100, as introduced, Hernandez. Continuity of care.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or a health insurer to provide for the completion of covered services by a terminated provider for enrollees or insureds who were receiving services from the provider for a specified condition at the time of the provider termination. Existing law also requires a health care service plan to provide for the completion of covered services by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for a specified condition. Existing law requires a health care service plan to provide a disclosure form regarding the benefits, services, and terms of a plan contract and requires the disclosure form to include a description of how an enrollee can request continuity of care under the provisions described above.

This bill would also require a health care service plan to include notice of the process to obtain continuity of care in every evidence of coverage issued after January 1, 2015. The bill would also require a plan to provide a written copy of this information to its contracting providers

and provider groups, as well as a copy to its enrollees upon request. The bill would make other technical changes to the provisions governing health insurers and continuity of care. Because a willful violation of the bill’s requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1373.96 of the Health and Safety Code
2 is amended to read:
3 1373.96. (a) A health care service plan shall at the request of
4 an enrollee, provide the completion of covered services as set forth
5 in this section by a terminated provider or by a nonparticipating
6 provider.
7 (b) (1) The completion of covered services shall be provided
8 by a terminated provider to an enrollee who at the time of the
9 contract’s termination, was receiving services from that provider
10 for one of the conditions described in subdivision (c).
11 (2) The completion of covered services shall be provided by a
12 nonparticipating provider to a newly covered enrollee who, at the
13 time his or her coverage became effective, was receiving services
14 from that provider for one of the conditions described in
15 subdivision (c).
16 (c) The health care service plan shall provide for the completion
17 of covered services for the following conditions:
18 (1) An acute condition. An acute condition is a medical
19 condition that involves a sudden onset of symptoms due to an
20 illness, injury, or other medical problem that requires prompt
21 medical attention and that has a limited duration. Completion of
22 covered services shall be provided for the duration of the acute
23 condition.
24 (2) A serious chronic condition. A serious chronic condition is
25 a medical condition due to a disease, illness, or other medical

1 problem or medical disorder that is serious in nature and that
2 persists without full cure or worsens over an extended period of
3 time or requires ongoing treatment to maintain remission or prevent
4 deterioration. Completion of covered services shall be provided
5 for a period of time necessary to complete a course of treatment
6 and to arrange for a safe transfer to another provider, as determined
7 by the health care service plan in consultation with the enrollee
8 and the terminated provider or nonparticipating provider and
9 consistent with good professional practice. Completion of covered
10 services under this paragraph shall not exceed 12 months from the
11 contract termination date or 12 months from the effective date of
12 coverage for a newly covered enrollee.

13 (3) A pregnancy. A pregnancy is the three trimesters of
14 pregnancy and the immediate postpartum period. Completion of
15 covered services shall be provided for the duration of the
16 pregnancy.

17 (4) A terminal illness. A terminal illness is an incurable or
18 irreversible condition that has a high probability of causing death
19 within one year or less. Completion of covered services shall be
20 provided for the duration of a terminal illness, which may exceed
21 12 months from the contract termination date or 12 months from
22 the effective date of coverage for a new enrollee.

23 (5) The care of a newborn child between birth and age 36
24 months. Completion of covered services under this paragraph shall
25 not exceed 12 months from the contract termination date or 12
26 months from the effective date of coverage for a newly covered
27 enrollee.

28 (6) Performance of a surgery or other procedure that is
29 authorized by the plan as part of a documented course of treatment
30 and has been recommended and documented by the provider to
31 occur within 180 days of the contract's termination date or within
32 180 days of the effective date of coverage for a newly covered
33 enrollee.

34 (d) (1) The plan may require the terminated provider whose
35 services are continued beyond the contract termination date
36 pursuant to this section to agree in writing to be subject to the same
37 contractual terms and conditions that were imposed upon the
38 provider prior to termination, including, but not limited to,
39 credentialing, hospital privileging, utilization review, peer review,
40 and quality assurance requirements. If the terminated provider

1 does not agree to comply or does not comply with these contractual
2 terms and conditions, the plan is not required to continue the
3 provider’s services beyond the contract termination date.

4 (2) Unless otherwise agreed by the terminated provider and the
5 plan or by the individual provider and the provider group, the
6 services rendered pursuant to this section shall be compensated at
7 rates and methods of payment similar to those used by the plan or
8 the provider group for currently contracting providers providing
9 similar services who are not capitated and who are practicing in
10 the same or a similar geographic area as the terminated provider.
11 Neither the plan nor the provider group is required to continue the
12 services of a terminated provider if the provider does not accept
13 the payment rates provided for in this paragraph.

14 (e) (1) The plan may require a nonparticipating provider whose
15 services are continued pursuant to this section for a newly covered
16 enrollee to agree in writing to be subject to the same contractual
17 terms and conditions that are imposed upon currently contracting
18 providers providing similar services who are not capitated and
19 who are practicing in the same or a similar geographic area as the
20 nonparticipating provider, including, but not limited to,
21 credentialing, hospital privileging, utilization review, peer review,
22 and quality assurance requirements. If the nonparticipating provider
23 does not agree to comply or does not comply with these contractual
24 terms and conditions, the plan is not required to continue the
25 provider’s services.

26 (2) Unless otherwise agreed upon by the nonparticipating
27 provider and the plan or by the nonparticipating provider and the
28 provider group, the services rendered pursuant to this section shall
29 be compensated at rates and methods of payment similar to those
30 used by the plan or the provider group for currently contracting
31 providers providing similar services who are not capitated and
32 who are practicing in the same or a similar geographic area as the
33 nonparticipating provider. Neither the plan nor the provider group
34 is required to continue the services of a nonparticipating provider
35 if the provider does not accept the payment rates provided for in
36 this paragraph.

37 (f) *Notice as to the process by which an enrollee may request*
38 *completion of covered services pursuant to this section shall be*
39 *provided in every disclosure form as required under Section 1363*
40 *and in any evidence of coverage issued after January 1, 2015. A*

1 *plan shall provide a written copy of this information to its*
2 *contracting providers and provider groups. A plan shall also*
3 *provide a copy to its enrollees upon request.*

4 ~~(f)~~

5 (g) The amount of, and the requirement for payment of,
6 copayments, deductibles, or other cost sharing components during
7 the period of completion of covered services with a terminated
8 provider or a nonparticipating provider are the same as would be
9 paid by the enrollee if receiving care from a provider currently
10 contracting with or employed by the plan.

11 ~~(g)~~

12 (h) If a plan delegates the responsibility of complying with this
13 section to a provider group, the plan shall ensure that the
14 requirements of this section are met.

15 ~~(h)~~

16 (i) This section shall not require a plan to provide for completion
17 of covered services by a provider whose contract with the plan or
18 provider group has been terminated or not renewed for reasons
19 relating to a medical disciplinary cause or reason, as defined in
20 paragraph (6) of subdivision (a) of Section 805 of the Business
21 and Profession Code, or fraud or other criminal activity.

22 ~~(i)~~

23 (j) This section shall not require a plan to cover services or
24 provide benefits that are not otherwise covered under the terms
25 and conditions of the plan contract. This section shall not apply to
26 a newly covered enrollee covered under an individual subscriber
27 agreement who is undergoing a course of treatment on the effective
28 date of his or her coverage for a condition described in subdivision
29 (c).

30 ~~(j)~~

31 (k) This section shall not apply to a newly covered enrollee who
32 is offered an out-of-network option or to a newly covered enrollee
33 who had the option to continue with his or her previous health plan
34 or provider and instead voluntarily chose to change health plans.

35 ~~(k)~~

36 (l) The provisions contained in this section are in addition to
37 any other responsibilities of a health care service plan to provide
38 continuity of care pursuant to this chapter. Nothing in this section
39 shall preclude a plan from providing continuity of care beyond the
40 requirements of this section.

1 (†)

2 (m) The following definitions apply for the purposes of this
3 section:

4 (1) “Individual provider” means a person who is a licentiate, as
5 defined in Section 805 of the Business and Professions Code, or
6 a person licensed under Chapter 2 (commencing with Section
7 1000) of Division 2 of the Business and Professions Code.

8 (2) “Nonparticipating provider” means a provider who is not
9 contracted with a health care service plan.

10 (3) “Provider” shall have the same meaning as set forth in
11 subdivision (i) of Section 1345.

12 (4) “Provider group” means a medical group, independent
13 practice association, or any other similar organization.

14 SEC. 2. Section 10133.56 of the Insurance Code is amended
15 to read:

16 10133.56. (a) A health insurer that enters into a contract with
17 a professional or institutional provider to provide services at
18 alternative rates of payment pursuant to Section 10133 shall, at
19 the request of an insured, arrange for the completion of covered
20 services by a terminated provider, if the insured is undergoing a
21 course of treatment for any of the following conditions:

22 (1) An acute condition. An acute condition is a medical
23 condition that involves a sudden onset of symptoms due to an
24 illness, injury, or other medical problem that requires prompt
25 medical attention and that has a limited duration. Completion of
26 covered services shall be provided for the duration of the acute
27 condition.

28 (2) A serious chronic condition. A serious chronic condition is
29 a medical condition due to a disease, illness, or other medical
30 problem or medical disorder that is serious in nature and that
31 persists without full cure or worsens over an extended period of
32 time or requires ongoing treatment to maintain remission or prevent
33 deterioration. Completion of covered services shall be provided
34 for a period of time necessary to complete a course of treatment
35 and to arrange for a safe transfer to another provider, as determined
36 by the health insurer in consultation with the insured and the
37 terminated provider and consistent with good professional practice.
38 Completion of covered services under this paragraph shall not
39 exceed 12 months from the contract termination date.

1 (3) A pregnancy. A pregnancy is the three trimesters of
2 pregnancy and the immediate postpartum period. Completion of
3 covered services shall be provided for the duration of the
4 pregnancy.

5 (4) A terminal illness. A terminal illness is an incurable or
6 irreversible condition that has a high probability of causing death
7 within one year or less. Completion of covered services shall be
8 provided for the duration of a terminal illness, which may exceed
9 12 months from the contract termination date.

10 (5) The care of a newborn child between birth and age 36
11 months. Completion of covered services under this paragraph shall
12 not exceed 12 months from the contract termination date.

13 (6) Performance of a surgery or other procedure that has been
14 recommended and documented by the provider to occur within
15 180 days of the contract's termination date.

16 (b) The insurer may require the terminated provider whose
17 services are continued beyond the contract termination date
18 pursuant to this ~~section~~, *section* to agree in writing to be subject
19 to the same contractual terms and conditions that were imposed
20 upon the provider prior to termination, including, but not limited
21 to, credentialing, hospital privileging, utilization review, peer
22 review, and quality assurance requirements. If the terminated
23 provider does not agree to comply or does not comply with these
24 contractual terms and conditions, the insurer is not required to
25 continue the provider's services beyond the contract termination
26 date.

27 (c) Unless otherwise agreed upon between the terminated
28 provider and the insurer or between the terminated provider and
29 the provider group, the agreement shall be construed to require a
30 rate and method of payment to the terminated provider, for the
31 services rendered pursuant to this section, that are the same as the
32 rate and method of payment for the same services while under
33 contract with the insurer and at the time of termination. The
34 provider shall accept the reimbursement as payment in full and
35 shall not bill the insured for any amount in excess of the
36 reimbursement rate, with the exception of copayments and
37 deductibles pursuant to subdivision (e).

38 (d) Notice as to the process by which an insured may request
39 completion of covered services pursuant to this section shall be
40 provided in any insurer evidence of coverage and disclosure form

1 issued after March 31, 2004. An insurer shall provide a written
2 copy of this information to its contracting providers and provider
3 groups. An insurer shall also provide a copy to its insureds upon
4 request.

5 (e) The payment of copayments, deductibles, or other
6 cost-sharing components by the insured during the period of
7 completion of covered services with a terminated provider shall
8 be the same copayments, deductibles, or other cost-sharing
9 components that would be paid by the insured when receiving care
10 from a provider currently contracting with the insurer.

11 (f) If an insurer delegates the responsibility of complying with
12 this section to its contracting entities, the insurer shall ensure that
13 the requirements of this section are met.

14 (g) For the purposes of this section, the following ~~terms have~~
15 ~~the following meanings:~~ *definitions apply:*

16 (1) “Provider” means a person who is a licentiate as defined in
17 Section 805 of the Business and Professions Code or a person
18 licensed under Chapter 2 (commencing with Section 1000) of
19 Division 2 of the Business and Professions Code.

20 (2) “Terminated provider” means a provider whose contract to
21 provide services to insureds is terminated or not renewed by the
22 insurer or one of the insurer’s contracting provider groups. A
23 terminated provider is not a provider who voluntarily leaves the
24 insurer or contracting provider group.

25 (3) “Provider group” includes a medical group, independent
26 practice association, or any other similar organization.

27 (h) This section shall not require an insurer or provider group
28 to provide for the completion of covered services by a provider
29 whose contract with the insurer or provider group has been
30 terminated or not renewed for reasons relating to medical
31 disciplinary cause or reason, as defined in paragraph (6) of
32 subdivision (a) of Section 805 of the Business and Professions
33 Code, or fraud or other criminal activity.

34 (i) This section shall not require an insurer to cover services or
35 provide benefits that are not otherwise covered under the terms
36 and conditions of the insurer contract.

37 (j) The provisions contained in this section are in addition to
38 any other responsibilities of insurers to provide continuity of care
39 pursuant to this chapter. Nothing in this section shall preclude an

1 insurer from providing continuity of care beyond the requirements
2 of this section.

3 SEC. 3. No reimbursement is required by this act pursuant to
4 Section 6 of Article XIII B of the California Constitution because
5 the only costs that may be incurred by a local agency or school
6 district will be incurred because this act creates a new crime or
7 infraction, eliminates a crime or infraction, or changes the penalty
8 for a crime or infraction, within the meaning of Section 17556 of
9 the Government Code, or changes the definition of a crime within
10 the meaning of Section 6 of Article XIII B of the California
11 Constitution.

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